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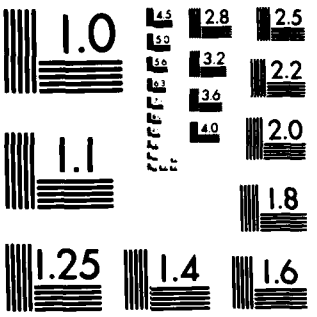

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Health, Committee on Ways and Means House of Representatives

July 1986

MEDICARE

Physician Incentive Payments by Hospitals Could Lead to Abuse

GAO/HRD-86-103

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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July 22, 1986

The Honorable Fortney H. Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

This report discusses operational and proposed incentive plans offered to physicians by hospitals and the features of such plans that could increase the risk of them having detrimental effects on quality of care for Medicare patients. ~~In it, we~~ suggest possible modifications to Medicare law that might deter physician incentive plans from providing too strong an incentive to undertreat patients.

As agreed with the Subcommittee office, we will not release this report until 3 days from its issue date unless the Subcommittee releases it earlier. At that time we will send copies to interested committees, the Secretary of Health of Human Services, and other parties.

Sincerely yours,

Richard L. Fogel
Director

Executive Summary

Purpose

During the past year, two physician incentive plans offered by hospitals have come under investigation for possible violation of Medicare law, one by the Department of Justice and the other by the Department of Health and Human Services' Office of Inspector General. These two cases have raised questions about the adequacy of the Medicare statute to deter abuses that may arise under the incentives of the Medicare prospective payment system for hospitals.

At the request of the Chairman, Subcommittee on Health, House Committee on Ways and Means, GAO obtained information on existing and proposed physician incentive plans and analyzed the plans to (1) assess their legality under current law and (2) determine the potential abuses that could arise under them in view of the changed incentives under prospective payment.

Background

Until fiscal year 1984, Medicare paid hospitals their reasonable costs of providing services to beneficiaries. Then, Medicare began to pay hospitals under a prospective payment system which, for the most part, pays hospitals an amount fixed in advance for each Medicare discharge.

This change in payment systems altered hospital incentives, which in turn changed the types of abuses that could occur. Under prospective payment, hospitals have financial incentives to underprovide services, discharge patients too early, and admit patients unnecessarily. The first two of these incentives were absent under cost reimbursement, which encouraged overprovision of services. Physician incentive plans, to a greater or lesser extent, provide the same incentives to physicians as those hospitals have under prospective payment because physicians are paid incentives for holding down hospital costs. (See p. 8.)

Medicare law has three main provisions to deter abusive practices. First, the law requires Peer Review Orgarizations, Medicare contractors that monitor hospital care, to review (1) the necessity of hospital admissions, (2) readmissions to hospitals to determine if premature discharges were involved, and (3) the quality of care provided by hospitals. These types of reviews should provide some deterrence against, and help identify instances of, abusive practices relating to physician incentive plans. (See p. 10.)

Second, Medicare can exclude from participation physicians and hospitals that are identified as furnishing inferior quality care to beneficiaries. This provision should also afford some deterrence against underprovision of services. (See p. 11.)

Third, Medicare's criminal provisions deter abuse resulting from paying kickbacks for the referral of beneficiaries for services. Because the incentives of the prospective payment system relate more to underproviding services than overusing them, Medicare's criminal provisions do little to deter abuse under the prospective system. (See p. 12.)

Results in Brief

GAO reviewed operational and proposed plans under which hospitals make incentive payments to physicians for keeping down the cost of treating patients and concluded that such plans can provide physicians too strong an incentive to undertreat patients. This could occur when the decision about whether to pay the incentive is based on the physician's success in keeping down the costs of only a few patients. In this circumstance, the costs of treating any one patient may have a decisive effect on the incentive payment, giving the physician a strong financial incentive to reduce the level of care given that patient, possibly below the level necessary to provide good quality care.

Medicare provisions were designed to deter abuse under a cost reimbursement system—typically overuse of services—not the prospective payment system's more likely abuse of underprovision of services. While some provisions have been adapted to deal with the changed incentives, they deal with quality of care problems on a case-by-case basis after the fact and do not address physician incentive plan features. GAO identified several such features that could be prohibited, or required, to deter potential abuse.

Principal Findings

Certain features of physician incentive plans could compromise the quality of care provided to Medicare beneficiaries because they can result in a close link between a physician's incentive payments and the treatment of individual patients (see ch. 3). These features are:

- Basing the decision to pay an incentive on the cost performance of a single physician, who, in most cases, will not admit a large number of Medicare patients to the hospital during any given period.
- Basing the decision to pay an incentive on the cost performance of a physician or group of physicians over a short period of time, such as a

month, which also reduces the number of patients over which cost performance is measured.

- Basing the amount of the physician's incentive payment on a percentage of the physician's contribution to the hospital's savings or profit.

On the other hand, the weaker the link between the physician's incentive payments and his or her treatment of individual patients, the weaker the physician's incentive to be cost conscious.

Also, failing to include explicit provisions for utilization and quality of care review in physician incentive plans increases the risk that quality of care will be adversely affected. Such review measures increase the risk of detection for abusers and provide a psychological reminder to physicians not to allow their concern about cost-conscious patient treatment to cause them to give patients inadequate care.

Finally, payments under physician incentive plans for holding down hospital costs under prospective payment can be viewed as being similar to kickbacks for referral for services under cost reimbursement. Both payments are made in the expectation that the payor will profit from the physician's action. Kickbacks for referral relate to the payor's ability to receive Medicare payment for the referred services, and incentive payments relate to the payor's higher profits under prospective payment from furnishing fewer services. However, the anti-kickback provision of Medicare law generally does not apply to payments under most types of physician incentive plans.

Matters for Consideration

In considering legislation to modify the Medicare statute to place restrictions on physician incentive plans, the Subcommittee may wish to consider prohibiting incentive plans unless hospitals base the decision of whether to pay an incentive on the cost performance of multiple physicians over a relatively long period of time, such as a year. In addition, the Subcommittee may wish to consider requiring such incentive plans to include explicit arrangements for utilization and quality review. Finally, the Subcommittee may wish to consider requiring that such plans not base the amount of incentive payments solely on each individual physician's cost performance.

Should the Subcommittee desire to impose criminal penalties on such incentive plans, it could modify the criminal provisions of the Medicare law to include a provision imposing penalties on hospitals and physicians giving or receiving payments from incentive plans that do not base

the decision of whether to pay incentives on the cost performance of multiple physicians over a relatively long period of time. (See p. 25.)

Agency Comments

GAO did not obtain comments on this report.

Contents

Abbreviations

DRG	diagnosis related group
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IPA	Independent Practice Association
MeSH	Medical Staff-Hospital Joint Venture
PPG	Primary Provider Group
PPS	prospective payment system
PRO	Peer Review Organization

Chapter 1

Introduction

On November 15, 1985, the Chairman, Subcommittee on Health, House Committee on Ways and Means, requested that we develop information on hospitals' physician incentive plans that are designed to reduce length of stay and service intensity for Medicare hospital inpatients. The Chairman also asked for our evaluation of the potential effects of such plans on the quality of care received by Medicare beneficiaries. Finally, we were asked for any recommendations we might have concerning these plans. In discussing this request, the Subcommittee's office expressed concern about the extent to which these plans were covered by current Medicare law, including Medicare's criminal provisions, and asked us to include a discussion of Independent Practice Association (IPA)[1] incentive plans for purposes of comparison.

Background

Medicare, administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS), is a health insurance program that covers almost all Americans age 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. The program, authorized under title XVIII of the Social Security Act, provides protection under two parts. Part A, the hospital insurance program, covers services of institutional providers of health care, primarily hospitals. Part B, the supplementary medical insurance program, covers many noninstitutional health services, with most payments for physician services. In 1985, Medicare paid out $47.7 billion under part A and $21.7 billion under part B for health care services for about 31 million beneficiaries.

Until fiscal year 1984, Medicare paid hospitals their reasonable costs of providing covered services to beneficiaries. Although this system had provisions designed to control Medicare cost growth, there was general concern that cost reimbursement did not give hospitals sufficient incentives to provide care economically and efficiently. Consequently, in the Social Security Amendments of 1983 (Public Law 98-21, Apr. 20, 1983), the Congress enacted a hospital prospective payment system (PPS) for Medicare. The new payment system is being phased in during fiscal years 1984-87. Under this system, payment rates are established at the beginning of each fiscal year for 468 diagnosis related groups (DRGs). Each DRG includes a set of physiologically related diagnoses expected to require about the same level of hospital resources to treat the patient.

[1]IPAs are a type of health maintenance organization in which a group of otherwise independent physicians contracts to deliver health care for a capitated fee.

This change in hospital payment methodology gave hospitals a changed set of incentives, which meant the possible emergence of new types of abuse of the Medicare program. Under cost reimbursement, the incentives could lead hospitals to overprovide services, extend lengths of stay, and unnecessarily admit patients. Under prospective payment, the incentives could lead hospitals to underprovide services, discharge patients too early, and as under cost reimbursement, unnecessarily admit patients.

Under the revised incentives of PPS, hospitals have offered, and health consultants have developed, physician incentive plans. Basically, these plans are designed to give physicians financial incentives similar to hospitals' financial incentives under PPS. Under physician incentive plans, physicians receive payments for holding down hospital costs for inpatients.

Medicare's Provisions for Controlling Program Abuse

The Chairman asked us to review the Medicare statute's provisions to see if they deterred abuse that could arise under physician incentive plans. The fraud and abuse provisions, which were generally enacted before PPS was established, were designed to deter problems that could arise in hospitals under the cost reimbursement system. Because the incentives of that payment system encouraged excessive utilization, Medicare has several provisions for preventing or controlling overutilization. Overprovision of services not only increases Medicare costs, but also can result in reduced quality of care for beneficiaries because there are risks inherent in many medical treatments. The Medicare statute includes (1) provisions for utilization and quality of care review of beneficiary hospital stays, (2) provisions permitting physicians and institutional providers (such as hospitals, skilled nursing facilities, or laboratories) to be denied the privilege of participating in the Medicare program if they chronically overuse services, and (3) criminal penalties designed to deter kickbacks for referring patients.

Under Medicare's cost reimbursement system, hospitals had incentives to encourage physicians to admit more Medicare patients, leave them in the hospital longer, and use more services while they were there. These incentives existed because Medicare paid its share of the costs of inpatient services based on the proportion of services used by Medicare patients. Thus, the more services Medicare patients used, the more the hospital was paid.

However, PPS gives hospitals a sharply changed set of incentives. Under this new system the payment level is, for the most part, independent of the number of services provided within a hospital stay. Furthermore, PPS permits hospitals to make a profit on Medicare patients if they are treated at a cost lower than the preset payment level. Thus, the shorter the patient's stay and the fewer services provided, the more likely the hospital is to make a profit on that patient. Only the incentive to admit more patients remains similar under both the old and new payment systems.

Hospitals generally do not determine the number and type of services provided to Medicare patients because this is usually determined by the patients' physicians. But the physicians, who are mostly still paid by Medicare on a fee-for-service basis, have no financial incentive to reduce the quantity of services. On the contrary, the shorter the hospital stay and the fewer the services given the patient, the lower the physician's Medicare payments are likely to be. Thus, hospitals could feel the need to give physicians a counterincentive to at least in part compensate them for payments they would forgo if they reduce length of stay and the number of services for Medicare patients.

Such incentive plans could damage the interests of Medicare beneficiaries and the program. If the incentives are too strong, they could conceivably lead to physicians reducing the amount of care given to the point of adversely affecting the quality of care. Furthermore, the Medicare program would be harmed if physicians, in order to receive incentive payments from hospitals, unnecessarily admit patients who could be adequately treated on an outpatient basis.

Some Deterrent Provisions Adapted to PPS

Two existing provisions of law intended to deter physicians and hospitals from abusing the Medicare program have been adapted to deal with problems that could arise under the changed incentives of PPS. When it enacted PPS, the Congress modified the functions of the utilization and quality control peer review organizations (PROs),[2] Medicare's hospital care monitoring bodies, to focus on the problems that might arise under PPS. Also, HHS has directed the PROs to refer quality of care cases for sanctions under the provisions permitting HHS to exclude physicians and hospitals from the program for abuse that might arise under PPS.

[2]The Peer Review Improvement Act of 1982, part of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), replaced Professional Standards Review Organizations with PROs. Both types of organizations were intended to perform utilization and quality of care review for Medicare beneficiaries.

PROs are intended to protect (1) the Medicare program against unnecessary hospital inpatient utilization and (2) Medicare beneficiaries against poor quality hospital care. The Congress modified the PROs' role to require that they deal with problems that could arise under the modified incentives of PPS. Section 1866(a)(1)(F) of the Social Security Act requires PROs to focus their efforts on unnecessary hospital admissions, premature discharges, and quality of care problems associated with undertreatment, all of which might arise under PPS incentives. PROs are to deny Medicare payment for unnecessary admission and refer physicians and hospitals they detect abusing the program to HHS.

Section 1866(b)(2)(F) of the Social Security Act permits HHS to exclude from the Medicare program any hospital which has "furnished services or supplies which are determined by [HHS] to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care." Section 1862(d) permits HHS to exclude physicians for similar reasons. Because underprovision of services, a potential problem under PPS, constitutes poor quality care, these provisions could be used to exclude physicians and hospitals that respond inappropriately to the incentives of PPS and undertreat patients.

These provisions constitute important safeguards for the beneficiaries and the program, but they have limitations. First, they can deal with problems only on a case-by-case basis. That is, they come into force only when specific cases of unnecessary admissions or poor quality care are detected. Also, in the case of excluding a physician or hospital, the provisions apply only when the specific actions of a physician or hospital can be shown to be the cause of the problem. Second, these provisions come into play only after the actions have been taken and the damage done. In the case of financial damage to the program, the money can usually be recovered. In the case of poor quality care, any action might come too late for the involved beneficiaries.

Criminal Provision Not Adapted to Changed Incentives[3]

The criminal provision of the Medicare statute applicable to payments by one party to another (42 U.S.C. 1395nn(b)(2)) states:

[3]We did not review non-Medicare criminal provisions that could be applicable to abuse that could arise under physician incentive plans.

"Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—
(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
(B) to purchase, lease, order or arrange for or recommend purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, shall be fined not more that $25,000 or imprisoned for not more than five years, or both."[4]

This provision was clearly intended to deter and punish kickbacks for referral of patients for services. In the hospital setting, kickbacks to physicians for admissions or the ordering of inpatient services would be contrary to the law. Thus, payments to physicians for admitting patients would be prohibited by the provision, and as mentioned above, additional admissions are one incentive hospitals have under PPS. However, incentive payments to physicians for ordering fewer services generally do not violate the provision.

Incentive payments to physicians for holding down hospital costs can be viewed as similar to kickbacks. A kickback for ordering additional services is a payment made to the physician because the hospital expects to profit from providing the services. An incentive payment to a physician to order fewer services under PPS is a payment made by the hospital because it expects to profit if it furnishes fewer services. Thus, both a kickback and an incentive payment would be payments made by a hospital in the expectation of increasing profits. If only unnecessary services are forgone, incentive payments could be viewed as a form of profit sharing. If necessary services are forgone, it would constitute a threat to the health of Medicare beneficiaries.

Chapter 3 discusses what kinds of physician incentive plan features could provide too strong an incentive to physicians to forgo needed services and how the law could be changed to prohibit including such features in physician incentive plans.

Objectives, Scope, and Methodology

As requested by the Chairman, Subcommittee on Health, House Committee on Ways and Means, the objectives of our review were to (1) analyze the effects of changed hospital incentives on the types of problems

[4]A parallel provision contains the same penalties for receiving kickbacks.

that could arise under PPS, (2) obtain information on the types of hospital physician incentive plans that have been implemented or proposed, (3) analyze these incentive plans to evaluate their legality under current Medicare law, and (4) review the plans to evaluate whether problems could arise under them.

As requested, we obtained information on two incentive plans that were under investigation (one by the Department of Justice and the other by HHS's Office of Inspector General), IPA physician incentive arrangements, and physician incentive arrangements under the Medical Staff-Hospital Joint Venture (MeSH) concept. We contacted officials of HCFA, the Department of Justice, and the HHS Office of Inspector General, as well as independent experts and health industry representatives, to discuss these four types of plans and attempt to identify other types of physician incentive plans that have been implemented or proposed. No other incentive plan types were identified.

We analyzed hospital incentives under PPS to identify what types of problems could arise that could be detrimental to the interests of Medicare beneficiaries or the program and what countermeasures might help to avoid such problems. We evaluated the features of the physician incentive plans to identify the types of abuse that could arise from the incentives in the plans. We also analyzed the incentive plans to estimate the extent to which their design could help prevent any potential problems from arising.

Because the applicability of Medicare's criminal provisions to physician incentive plans has not been tested in the courts, we are not commenting on the legality of most of the plans discussed in this report.

Our work was conducted from January through April 1986. As requested by the Subcommittee's office, we did not obtain comments on this report. Except as noted above, our work was done in accordance with generally accepted government auditing standards.

Chapter 2

Features of Physician Incentive Plans

We identified four types of physician incentive plans either in operation or proposed. While some of these plans incorporate some safeguards that could reduce the level of risk to quality care for Medicare beneficiaries, others do not. If applied to Medicare patients, the plan developed by Pasadena General Hospital, Pasadena, Texas, would likely violate the Medicare anti-kickback statute.

Paracelsus Plan

While the details of the physician incentive plans used at the 14 hospitals in the Paracelsus Healthcare Corporation chain vary somewhat, they are basically similar. In each hospital, total hospital charges for Medicare patients admitted by each physician are compared on a month-by-month basis to Medicare prospective payments for those patients. If Medicare payments for a physician's patients for a month are above a set percentage of hospital charges for that month (70 or 75 percent in those we examined),[1] the physician is paid a percentage of the difference.

Based on review of written descriptions of the incentive plan used by Paracelsus in its California hospitals, the plan includes a combination of features that, taken together, may give physicians too strong an incentive for underprovision of services and possibly for unnecessary admissions. For example, in one Paracelsus hospital the plan worked as follows. If in a particular month, a physician admitted patients for whom the hospital received Medicare payments totaling more than 75 percent of the total hospital charges for these patients, the physician would be paid 10 percent of the amount between 75 percent and 85 percent of the hospital charges, 15 percent of the amount between 85 percent and 95 percent, and 20 percent of the amount greater than 95 percent.

If total hospital charges for Physician X's Medicare patients in one month were $65,000, Physician X would share in any Medicare payments exceeding 75 percent of the total charges, or $48,750 ($65,000 in charges times 75 percent equals $48,750). If Medicare's payments for Physician X's patients totaled $70,000, the physician would receive an incentive payment of $3,275 for the month in question, calculated as shown in table 2.1.

[1]Hospital charges are normally higher than actual costs so that 70 or 75 percent of charges may be close to the actual costs of these hospitals for caring for the patient. Thus, payments in excess of this amount may represent a profit to the hospital.

Table 2.1: Hypothetical Calculation of Incentive Payment for a Physician

Payment amount above 75 percent of hospital charges	Dollar amount in each range	Physician's incentive percentage of the dollar amount in each range	Physician's incentive payment
75-85%	$6,500[a]	10	$ 650
85-95%	6,500	15	975
Over 95%	8,250	20	1,650
Total			**$3,275**

[a]Computed as follows: 85 percent times $65,000 in charges minus 75 percent times $65,000 in charges equals $55,250 minus $48,750 equals $6,500. The other amounts in this column are computed in a similar way.

The Paracelsus plan is the subject of an investigation by the HHS Office of Inspector General. As of May 1986, that Office had not determined whether in its opinion the plan is legal.

We believe that certain features of the plan make the incentives too strong for physicians to underprovide services or admit patients to the hospital who might not need hospitalization. First, the period of time over which the incentive operates—1 month—seems too short to us. Such a short period gives the physician an incentive to arrange his practice so that as many low-cost patients as possible are admitted in a given month. To do this the physician could attempt to postpone admissions of sicker patients or admit them to another hospital if he or she had admitting privileges at more than one hospital. Or the physician could order few services or discharge the patient early to reduce hospital charges.

Second, this plan makes the single physician the unit on which the incentive is paid. That is, to determine whether the hospital will make an incentive payment to a physician, and how large it will be, the hospital compares the payments and charges for the patients of that physician. Thus, the fewer services provided to the physician's patients, the lower the hospital charges and the higher the physician's incentive payment. This, in turn, increases the incentive to the physician to undertreat his or her patients.[2]

[2]The physician could also have an incentive to report a diagnosis that falls into a DRG with a higher payment rate rather than the actual diagnosis for which the patient was hospitalized. This could result in the hospital receiving a higher payment from Medicare and thereby enhance the physician's incentive payment from the hospital.

Third, the plan provides for payment to the physician of a percentage of the hospital's profits on that physician's Medicare patients. Furthermore, the percentage escalates as the profit increases. We believe that this arrangement, especially when coupled with the short-term and single-physician features discussed above, could increase the incentive to physicians to undertreat patients.

Finally, the Paracelsus plan does not include any built-in counterincentive or control mechanism, such as a quality review program, to prevent or identify abuse. An official of the California PRO told us in May 1986 that surveillance by the PRO had not identified any quality of care problems that could be traced to the incentive plan at Paracelsus hospitals.

MeSH Physician Incentive Plan

The Medical Staff-Hospital Joint Venture concept was formulated at Interstudy, a nonprofit health consulting company, as a response to what the developers describe as the "industrialization" of health care in the United States resulting from the introduction of price competition and the emergence of the corporate health care organization. MeSH plans are intended to foster joint hospital-physician cooperation in several areas and need not necessarily include a physician incentive arrangement. One knowledgeable consultant told us that as far as he knew, no existing MeSH plans include physician incentive arrangements, in part because of concern about their legality. Therefore, since we lacked an operational example of such an arrangement, we considered the MeSH physician incentive arrangement concept on the basis of proposals put together by its developers.

As designed, the MeSH DRG incentive arrangement incorporates several features that, taken together, reduce the potential for adverse effects on the quality of care. It is designed to be applied to Medicare patients, but could be used for any patients whose care is paid for under a prospective payment system.

As envisioned by the developers of the MeSH concept, the physician incentive program would be set up as a separate entity, called a "DRG Venture," controlled and operated by the MeSH, which in turn is jointly owned by the hospital and participating medical staff. The hospital would contract with the DRG Venture and set aside a budgeted amount for physician incentive payments to be paid if costs of care for Medicare patients are below a targeted amount.

To separate those cost factors over which the hospital has control from those over which the physician has control, the hospital and the DRG Venture would first negotiate a standard unit cost for each hospital service. The hospital would accept the risk of producing services at or below these standard unit costs. Using these standard costs as a basis, the DRG Venture and the hospital would establish a baseline measure of average cost per discharge and a schedule of target costs per discharge for each DRG, the latter being set below the former. The DRG Venture would track the performance of each physician and of all the physicians collectively. Before the incentive pool was released by the hospital, all Medicare cases admitted to the hospital (not just those of physicians participating in the plan) would have to have average costs below the baseline costs. An additional incentive payment would be added if overall average costs fell below target costs. In summary, the payment of the incentive is based on average utilization of all the Medicare patients of all the hospital's physicians over the year.

Physicians whose individual annual cost performance was negative (that is, the standard costs of treating their patients were above the baseline costs) would not receive incentive payments. The authors of the plan recommended that the incentive payment be divided among the physicians who had a positive cost performance in the ratio of the individual physician's net savings to the sum of the savings generated by all participating physicians. This arrangement somewhat increases the physicians' incentive to undertreat patients over what it would be if the incentive pool was divided evenly among all physicians with costs below the target cost. This results because the size of each physician's incentive payment is directly related to his or her cost performance. It has the effect of partially negating the advantage of grouping physicians together to determine if the incentive should be paid.

The developers of the plan attempted to build in an incentive for physicians to give patients good quality care. In the absence of a reliable, objective measure of quality of care, they recommended that the hospital set up an additional pool of funds whose payment to physicians would be contingent upon whether "patient satisfaction" was at an acceptable level. They suggested that satisfaction be measured by patient surveys and by the number of malpractice claims against the hospital. If these indicators were in the acceptable range (that is, met targets preset by the hospital and the DRG Venture), this additional pool would be released to be divided among physicians who had experienced

no malpractice claims during the year. Although this feature is conceptually desirable, we do not know if it would be very effective in deterring undesired behavior by physicians because of the difficulty in measuring patient satisfaction and because of the long periods that may elapse between a hospital stay and the filing and settling of a related malpractice claim.

Finally, the authors of the plan incorporated utilization and quality review systems as an integral part of the DRG Venture. The utilization review program would screen admissions to minimize the possibility of PRO denial of payment for inappropriate admissions. It would also review length of stay, ancillary services use, and discharge planning to help the physicians identify areas for improving their cost performance and the hospital identify physicians whose practice patterns could be made less costly.

Quality review would be aimed at protecting the patient—and the hospital—against the possibility that in attempting to reduce the cost of care, physicians would reduce the level of services provided too far, either unwittingly or in a deliberate attempt to abuse the program. The hospital's interests are at stake here also because both the hospital's reputation as a quality provider and its financial soundness, because of possible liability claims, may be impaired if standards of care are compromised.

IPA Physician Incentive Plans

Independent Practice Associations are a form of health maintenance organization (HMO) in which a group of otherwise independent physicians contract to deliver health care for a capitated fee. Such physicians usually also have a non-HMO practice, which in many cases is larger than their HMO practice. Physician incentive arrangements as practiced by IPAs are quite different from the hospital incentive plans discussed above. First, such incentive plans typically cover outpatient as well as inpatient care. Second, IPA plans usually require the physicians to share a part of the IPA's risk.

The American Medical Care and Review Association, a trade group representing primarily IPAs, supplied to us, as a typical example of an IPA physician incentive plan, the one used by HealthPlus of Michigan. Under this plan, financial incentive arrangements center on a group of primary care physicians (referred to as a Primary Provider Group (PPG)) who generally utilize the same hospital. This group enters into an arrangement with the hospital, and the two together provide or arrange for all

medical and hospital services covered by HealthPlus in return for a monthly capitation payment.

This capitation is paid into a separate fund for each PPG. Participating physicians and the hospital are paid from the PPG's fund on a fee-for-service basis at rates at least as high as those received in the area from other major insurance carriers. The level of these fees is negotiated in advance.

A percentage of each physician's fee is withheld and placed in a risk reserve fund. In this IPA, the percentage is adjustable depending on the PPG's past success or failure in keeping costs below the budgeted level. (An industry expert told us that withholding about 20 percent is typical.)

If the PPG spends less than the capitation payments, it receives part of the savings. If, on the other hand, the PPG spends more, funds from the risk reserve are used to cover the difference up to the amount in the risk reserve fund. The budget period covers a full year. To guard against the occasional catastrophically expensive case, HealthPlus of Michigan has set up a reinsurance fund to cover the cost of care for individual patients who exceed a dollar threshold during any calendar year.

The PPG is permitted to divide any funds remaining in its risk fund among its member physicians using one of several alternative methods. In any case, making the PPG, rather than the individual physician, the unit on which to determine whether incentive payments are made tends to reduce the directness of physicians' incentives because it averages cost performance over many physicians' patients, rather than over those of a single physician.

Because the PPG physicians share in the overall profits, if there are any, of their patients' entire care, rather than just of inpatient care as in the plans discussed above, they have an incentive to substitute outpatient treatment for more costly hospital care. Thus, physicians have no incentive to unnecessarily hospitalize beneficiaries. In addition, each PPG has a utilization review committee, which reviews member practice patterns based on physician billings.

There is no discussion of a quality assurance program in the materials supplied on HealthPlus of Michigan's incentive plan. However, HCFA requires that HMOs with contracts to serve Medicare patients have such a program.

Pasadena General Hospital Plan

Pasadena General Hospital's physician incentive plan is not like the other types of plans discussed in this report. Rather than making payments to physicians for holding down hospital costs, it involved paying a specific sum, allegedly $70 per patient, to physicians to admit patients to the hospital. Payments, according to the government, began in March 1985. This plan was the subject of a investigation by the Department of Justice, which resulted in a November 1985 indictment alleging that these payments had been made to induce physicians to admit Medicare patients, which would appear to be illegal under Medicare's anti-kickback provision cited on page 12. The defendant admitted that physicians were paid to induce them to admit non-Medicare patients, but not Medicare patients. The case went to trial and resulted in a verdict of not guilty. Apparently, the verdict turned on the fact that the government did not prove that physicians were paid to admit Medicare patients.

This type of plan, unlike the other three, is not designed to encourage physicians to treat their hospitalized patients more economically, but rather to admit them to the hospital. If applied to Medicare patients, it has the potential to harm the program if it encourages physicians to hospitalize patients who could be adequately treated as outpatients.

Chapter 3

Medicare Law Could Be Changed to Deter Abuses That Could Arise Under Physician Incentive Plans

Because the Medicare provisions designed to deter abuse were generally enacted before the advent of PPS, they may not be adequate to deal with the somewhat different types of incentives and potential abuses that could arise under this new system. Under PPS the possibility exists that physician incentive plans provided by hospitals may give physicians too strong an incentive to admit Medicare beneficiaries unnecessarily or reduce to unacceptable levels the amount of care provided. Changes may be needed in these provisions to deter potential abusers and remind physicians that they need to guard against allowing the cost-conscious behavior that PPS was designed to encourage to slide into providing inadequate care for Medicare beneficiaries.

Plan Characteristics Indicating High Risk

Several characteristics of physician incentive plans, singly or in combination, may tend to give physicians too strong an incentive to reduce quality of care to Medicare patients. In general, the larger the number of patients over which the incentive is determined, the weaker the physician's incentive to prescribe substandard care to any particular patient. Also, plans that lack explicit counterincentives or quality assurance mechanisms may be risky in regard to controlling incentives to underprovide services.

One physician incentive plan characteristic is the length of the period over which the physician's cost performance is assessed to determine the level of incentive payment. During a short period, such as a month, most physicians will not admit a large number of patients to a hospital. Thus, admitting a patient who is sicker than usual, or who needs a lot of ancillary services compared with other patients in the same DRG, may have a considerable effect on that physician's incentive payment for that month. In this circumstance, the physician might have a fairly strong financial incentive to skimp on the patient's treatment to keep costs down. This incentive would be considerably weaker if the period over which the physician's performance is assessed to determine if he or she should receive an incentive payment is longer, such as a year, because this increases the number of patients over which cost performance is determined.

A second characteristic that would tend to affect the number of patients over which physician cost performance is determined, and thus the risk of giving physicians too strong an incentive to reduce quality of care to Medicare patients, is the number of physicians over which cost performance is calculated to determine if an incentive will be paid. If this decision is based on the patients of a single physician, the number of

patients over which performance is calculated will be relatively low. However, if the costs are calculated over the patients of several physicians, a particular patient of one physician is not likely to have much effect on the amount of the incentive payment because of the larger number of patients involved in determining any incentive payments. Thus, the physician's incentive to undertreat is correspondingly weaker. We believe that using a group of physicians rather than a single physician as the basis for the incentive decision is preferable.

We also believe that physician incentive plans should include explicit mechanisms designed to prevent and identify undesired physician behavior. Mechanisms such as utilization and quality review provide two benefits. First, they increase the physician's risk of detection if he or she abuses the incentive program. Second, they create a psychological reminder to physicians that they need to be careful that the desired behavior—considering cost as a factor when deciding how best to treat a patient—does not become undesired behavior—giving a patient inadequate treatment.

Another characteristic of hospital incentive plans that may affect physicians' financial incentives to undertreat patients is the use of arrangements under which the physician is paid a percentage of savings or profits. Under such percentage arrangements, the more the physician is able to reduce the costs of treating patients, the greater the cost savings and the more he · she will receive as an incentive payment. This means that physicians will have a stronger incentive to reduce the number of services provided, especially the more costly services, to reduce the hospital's cost for that patient and thereby increase incentive payments. This could have the effect of reducing the level of care provided the beneficiary to the point of affecting quality of care.

No Guarantee Against Abuse

Despite features of physician incentive plans that may reduce financial incentives to physicians to give substandard treatment to Medicare patients, we do not believe that any combination of features can guarantee that a plan will not be subject to abuse. These features will only render abuse less likely. The protection afforded by these features in large part depends on the good faith of those administering the plans. No plan, no matter how well designed, can guard against abuse if those in charge do not operate the plan in a manner that deters abuse.

It is important to recognize that features built into a plan to prevent abuse also reduce the incentive for the physician to behave in the desired cost-conscious manner.

Conclusions

Two of the Medicare statute's provisions—PRO review of unnecessary admission, premature discharges, and quality of care and the authority to exclude from Medicare participation physicians and hospitals that furnish inferior quality care—can, in our opinion, be used to identify and sanction instances of poor care that could arise under physician incentive plans. These provisions are likely to identify and sanction physicians and hospitals on an individual patient basis after the abusive practice has occurred and the harm has been done. A third provision—criminal penalties for kickbacks for referral for services—while appropriate to deter and punish abuse likely to occur under cost reimbursement, is generally not applicable to the more likely abuse of underprovision of services under PPS.

The Medicare statute could be amended to deter physician incentive plans from resulting in abusive practices by prohibiting the features of the plans likely to provide too strong an incentive to undertreat patients and by requiring features that mitigate against possible abuse. Such amendments would help address systemic problems that could arise under physician incentive plans, whereas current provisions are more directed at individual cases of abusive practice. If, as the Subcommittee's office indicated to us, the Subcommittee desires to modify Medicare's criminal provisions to deter abuse under physician incentive plans, certain features could be made illegal under the criminal provision.

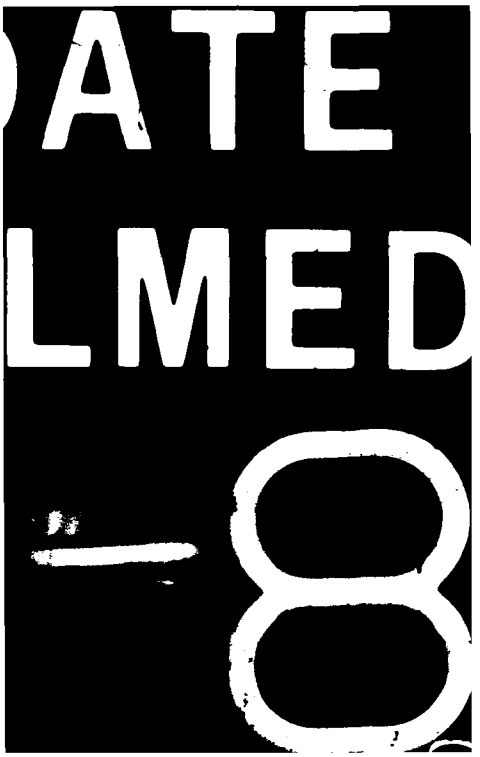
We believe that the risk of abuse under physician incentive plans could be reduced by requiring that incentive payment decisions be made by averaging costs versus payments over a fairly large number of patients, thus reducing physician incentives to undertreat any particular patient. This could be achieved by requiring incentive payments to be based on the cost performance of a group of physicians. Also, the minimum period of time for calculating incentive payments could be required to be relatively long, such as a year. In addition, we believe that requiring that incentive plans contain explicit provision for utilization and quality review might also prove helpful in deterring abuse.

It might also be desirable to prevent the use of arrangements whereby a physician's incentive payment is calculated solely on his or her cost performance because such an arrangement tends to negate the advantage of requiring that the incentive unit be a group of physicians. This results because the physician is still paid based on his or her personal overall cost performance.

Matters for Consideration by the Subcommittee

In considering legislation to modify the Medicare statute to place additional restrictions on physician incentive plans, the Subcommittee may wish to consider prohibiting incentive plans unless hospitals base the decision of whether to pay an incentive on the cost performance of multiple physicians over an extended period of time. In addition, the Subcommittee may wish to consider requiring such incentive plans to include explicit arrangements for utilization and quality review. Finally, the Subcommittee may wish to consider requiring that such plans not base the amount of incentive payments solely on each individual physician's cost performance.

In addition, should the Subcommittee desire to place criminal sanctions on physician incentive plans, it could modify the criminal provisions of the Medicare law to include a provision imposing sanctions on hospitals and physicians who give or receive payments under incentive plans that do not base the decision of whether to pay incentives on the cost performance of multiple physicians over an extended period of time.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